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Psychodynamic Psychotherapy in 2010

Abstract *This article attempts to discern the future of psychodynamic psychotherapy. Of increasing interest are (1) developmental arrests in infancy and early childhood; (2) focus on treatment of personality disorders and "difficult" patients; (3) the dyadic character of the therapeutic relationship; (4) the therapeutic alliance; (5) developments in neuroscience and pharmacotherapy; (6) group, couple, and family therapies; (7) brief and time-limited therapies; (8) attempts to devise specific treatments for specific disorders; (9) treatment manuals; and (10) continued search for the mechanisms of change in personality and behavior.*

Psychodynamic theory and practice have proven remarkably viable and adaptable, a judgment that is exemplified throughout.

Keywords: *Psychotherapy, future outlook, psychotherapy practice, outlook prognostications.*

Zusammenfassung *Dieser Artikel stellt den Versuch dar, ein Bild der Zukunft der psychodynamischen Psychotherapie zu entwerfen. Von zunehmendem Interesse sind: 1. Entwicklungshemmungen im Säuglingsalter und in der frühen Kindheit; 2. die Behandlung von Persönlichkeitsstörungen und „schwierigen" Patienten; 3. die dyadische Natur der therapeutischen Beziehung; 4. das therapeutische Arbeitsbündnis; 5. Entwicklungen in Neurowissenschaften und Pharmakotherapie; 6. Gruppen-, Ehe- und Familientherapien; 7. Kurztherapien und zeitlich limitierte Therapien; 8. Versuche, spezifische Behandlungsmethoden für spezifische Störungen zu entwickeln; 9. Behandlungsmanuale; 10. das ständige Suchen nach den Mechanismen der Veränderung in Persönlichkeit und Verhalten.*

Psychodynamische Theorie und Praxis haben sich als bemerkenswert lebens- und anpassungsfähig erwiesen – eine Feststellung, die durchwegs an Beispielen erläutert wird.

Schlüsselwörter: *Psychotherapie, Zukunft der Psychotherapie, Psychotherapie-Praxis.*

La psychothérapie en l'an 2010

Résumé *Dans le présent article, je tente de prévoir ce que sera l'avenir de la psychothérapie psychodynamique. J'ai en particulier cerné les tendances suivantes:*

1. On porte une attention plus particulière aux troubles et blocages de la petite enfance. Au lieu de simplifier la tâche du thérapeute, cette tendance rend le processus plus compliqué et fait augmenter la durée du traitement et ses difficultés.

2. La majorité des traitements ne concernent plus les névroses classiques, mais les problèmes de patients "plus difficiles" (ex.: troubles de la personnalité, borderline et troubles narcissiques).

3. Une plus grande importance est attribuée à la dyade caractérisant la relation thérapeutique, une attention particulière étant portée aux phénomènes de transfert et de contre-transfert. Le contre-transfert en particulier ne sera plus considéré comme un produit secondaire négatif qui peut être éliminé ou du moins atténué grâce à l'analyse personnelle du thérapeute. La mise en scène par le patient d'émotions, d'idées ou d'actes gênants est considérée comme résultant d'une longue histoire personnelle et comme le problème vraiment central de la "maladie" traitée. Il est donc inévitable que le thérapeute manifeste de fortes réactions à cette mise en scène, et celles-ci peuvent remplir une fonction extrêmement importante en l'aidant à traiter les problèmes interpersonnels et intrapsychiques de son patient. L'outil principal de l'analyste est une attitude de curiosité empathique qui produit "une illumination et transformation progressive du monde subjectif du patient" (Stolorow, 1990, p. 26). L'idée de "transfert non-contaminé" (Gill, 1982, p. 175) est une illusion, du fait que patient et thérapeute contribuent à donner sa forme à ce dernier. Il n'est en outre plus possible de soutenir l'idée qu'une interprétation authentique du transfert ne contient pas de "suggestions".

4. La relation patient-thérapeute, y compris l'alliance thérapeutique, va jouer un rôle de plus en plus central, au niveau de la pratique comme à celui de la recherche.

5. On admet de mieux en mieux que pharmacothérapie et psychothérapie doivent se compléter et qu'il

faut que la collaboration entre les spécialistes de ces deux disciplines s'améliore.

6. Bien que la majorité des thérapies se fassent encore en setting individuel, les thérapies de groupe, et les thérapies familiales ou de couple continuent à jouer un rôle clef.

7. L'accent continue à être mis sur des formes plus brèves de thérapie. Celles-ci incluent des aspects importants: intervention rapide, évaluation dès le début du traitement, établissement précoce d'une relation interpersonnelle, gestion par le thérapeute des restrictions temporelles, visées thérapeutiques limitées, processus dirigé plus fortement par le thérapeute, établissement d'un focus dynamique, ventilation ou catharsis, ainsi que flexibilité dans le choix d'une technique.

8. On continue à tenter d'élaborer des traitements spécifiques concernant des troubles spécifiques – une tendance qui est fortement encouragée par les organismes de "gestion des soins".

9. Les manuels de traitement sont plus fréquemment utilisés comme guides au niveau du travail pratique et de la recherche.

10. On continue à tenter de mieux saisir les mécanismes d'évolution, c'est-à-dire la manière dont la psychothérapie apporte une modification de la personnalité et du comportement. Les possibilités suivantes sont envisagées en tant que facteurs: a) la relation du patient au thérapeute et b) une forme ou une autre d'intervention technique. Il pourrait s'avérer que les facteurs les plus thérapeutiques sont ceux trouvés, de manière non-spécifique, dans toutes les relations humaines positives. Pourtant, des aptitudes thérapeutiques spécifiques occuperont une place importante; ce sont elles qui permettent de gérer la relation interpersonnelle de manière compétente. En d'autres termes, il se peut que le facteur thérapeutique central soit l'expérience faite par le patient du thérapeute en tant que "Autre signifiant"; il peut alors introjecter les émotions, attitudes et valeurs de cet Autre, ce qui permet de corriger les expériences qu'il a faites dans son enfance.

Il faut prévoir que la distinction faite entre psychothérapie expressive (considérée autrefois comme le domaine de la psychanalyse) et psychothérapie de support (caractérisant d'autres formes de thérapie) perdra de son importance. On admet maintenant que toutes les formes de thérapie dynamique incluent simultanément des éléments expressifs et de support.

Il est aussi inévitable que l'on devienne plus réaliste et définisse de manière plus précise à la fois les potentiels et les limites de la psychothérapie. Comme le montre en particulier l'élaboration de nombreuses approches limitées dans le temps ou à court terme, les thérapeutes vont renoncer aux visées perfectionnistes qui, autrefois, dominaient leur discipline. Ils vont se rendre compte qu'il est rare que la psychothérapie guérisse de manière durable; ils accepteront mieux le fait que de nombreux patients requièrent un soutien répété. Bref, patients comme thérapeutes vont probablement viser une amélioration au lieu d'une guérison (si tant est que celle-ci ait jamais été possible).

Les diverses modifications de la théorie et de la pratique qui jouent actuellement un rôle de premier plan vont continuer à fournir nouvelles force et vitalité à la thérapie psychodynamique, contrairement à ce qui s'est passé il y a quelques décennies, lorsqu'elle fut pratiquement éclipsée par la thérapie du comportement.

N'oublions pas de mentionner le fait que de très nombreuses personnes vont devenir thérapeutes, ce qui implique un problème de formation. On peut s'attendre à ce qu'elles viennent de disciplines très variées, et que les unes disposent d'une formation et d'une expérience très complètes alors que les autres seront peu qualifiées. Parallèlement, les filières de formation continueront à appliquer des standards très variables. De nombreux soi-disant thérapeutes seront mal équipés pour assumer leurs responsabilités, au niveau personnel comme au niveau professionnel.

On peut s'attendre à une amélioration de la formation mais celle-ci demeurera sans doute une sorte de mosaïque, les différentes filières présentant d'importantes différences. Par contre, il est certain que l'on sera en mesure de mieux utiliser les moyens techniques, tels le CD-ROM et autres innovations, ce qui permettra d'exploiter les progrès accomplis dans le domaine de l'éducation et de la pédagogie.

A un autre niveau, il ne faudrait pas négliger le rôle de plus en plus important joué par la recherche contrôlée. Le domaine de la recherche en psychothérapie, autrefois réservé à quelques intrépides, va être mieux apprécié par les spécialistes et la société.

Finalement et que cela nous plaise ou non, la pratique de la psychothérapie sous toutes ses formes va être considérablement influencée par le développement de la gestion des soins, y compris l'importance que cette branche attribue aux traitements de courte durée adaptés à des troubles spécifiques, à des visées limitées et au contrôle des coûts. La psychothérapie dynamique ouverte va demeurer un luxe que ne peuvent s'offrir que relativement peu de membres de notre société. Il reste qu'une approche sans limite stricte dans le temps, soulignant l'épanouissement de la personnalité plutôt que la gestion de symptômes cliniques, va certainement survivre – du moins en tant qu'idéal. C'est en tout cas ce que j'espère.

Psychodynamische Psychotherapie im Jahre 2010

Zusammenfassung *In diesem Artikel unternehme ich den Versuch, ein Bild der Zukunft der psychodynamischen Psychotherapie zu entwerfen. Ich habe vor allem die folgenden Tendenzen beobachtet:*

1. Immer mehr Aufmerksamkeit wird den Störungen und Hemmungen im Säuglings- und frühen Kindesalter gewidmet. Dies vereinfacht die Aufgabe des Therapeuten keineswegs, sondern macht im Gegenteil

den Prozeß eher komplizierter, verlängert die Behandlung und erschwert sie.

2. Das Schwergewicht der Behandlung hat sich verlagert von den klassischen neurotischen Zustandsbildern zu den Problemen „schwierigerer" Patienten, (z.B. Persönlichkeitsstörungen, Borderlinezuständen und narzißtischen Persönlichkeitsstörungen).

3. Stärker betont wird die dyadische Natur der therapeutischen Beziehung, wobei besondere Aufmerksamkeit auf Übertragungs-und Gegenübertragungsphänomene gerichtet wird. Insbesondere wird die Gegenübertragung nicht länger als unerfreuliches Nebenprodukt betrachtet, das eliminiert oder doch wenigstens gemildert werden kann durch die persönliche Analyse des Therapeuten. Statt dessen wird das Inszenieren von störenden Mustern des Fühlens, Denkens und Handelns durch den Patienten als Folge einer langen Geschichte betrachtet, und sie sind in der Tat ein zentrales Problem der „Krankheit", die behandelt werden soll. Aus diesem Grund ist es auch nicht zu vermeiden, daß der Therapeut starke Reaktionen auf die Inszenierungen des Patienten entwickelt, und diese können eine äußerst nützliche Hilfe für den Therapeuten sein im Umgang mit den zwischenmenschlichen und innerseelischen Problemen des Patienten. Das wichtigste Instrument des Therapeuten ist ein kontinuierliches empathisches Nachfragen, das schließlich zu einer „sich entfaltenden Erhellung und Veränderung der subjektiven Welt des Patienten" führt (Stolorow, 1990, S. 26). Weil sich die Übertragung aus Beiträgen des Patienten wie des Therapeuten bildet, ist der Begriff einer „unkontaminierten Übertragung" eine Illusion (Gill, 1982, S. 175). Des weiteren ist die ursprüngliche Annahme, daß eigentliche Übertragungsdeutungen keine „Suggestionen" enthielten, unhaltbar.

4. Die Beziehung zwischen Patient und Therapeut, einschließlich das therapeutische Arbeitsbündnis, wird vermehrt ins Zentrum der Betrachtung rücken, sowohl in der Praxis wie in der Forschung.

5. Es wird zunehmend erkannt, daß Pharmakotherapie und Psychotherapie Hand in Hand gehen müssen, und daß Psychotherapeuten und Pharmakotherapeuten vermehrt zusammenarbeiten müssen.

6. Obwohl individuelle Psychotherapie die zentrale Form geblieben ist, werden Gruppen-, Familien- und Ehetherapie weiterhin eine wichtige Stellung einnehmen.

7. Vor allem die kürzeren Formen der Psychotherapie werden weiter im Vordergrund stehen. Wichtige Kennzeichen hier sind: Prompte Intervention, schnelle, frühe Erfassung, rasches Herstellen einer zwischenmenschlichen Beziehung, das Umgehen des Therapeuten mit zeitlichen Begrenzungen, eine Einschränkung der therapeutischen Ziele, ein direktiveres Verhalten des Therapeuten, das Herstellen eines dynamischen Fokus, Ventilation oder Katharsis, Flexibilität in der Wahl der Technik.

8. Die Suche nach spezifischen Behandlungsformen für spezifische Störungen wird weitergehen, ein Trend, der auch von Organisationen der „Managed Care" unterstützt wird.

9. Behandlungsmanuale werden eher noch populärer werden und Behandlung wie Forschung beeinflussen.

10. Das Interesse an einem besseren Verständnis der Veränderungsmechanismen in der Psychotherapie wird wachsen, das heißt an der Frage, wie es zu Veränderungen der Persönlichkeit und des Verhaltens kommt. Die wichtigsten Alternativen sind a) die Beziehung des Patienten zum Therapeuten und b) gewisse Formen der technischen Intervention. Möglicherweise werden sich die allen guten menschlichen Beziehungen gemeinsamen oder nichtspezifischen Faktoren als besonders therapeutisch erweisen. Doch werden spezifische therapeutische Fähigkeiten, die in der kompetenten Handhabung der zwischenmenschlichen Beziehung bestehen, einen wichtigen Platz einnehmen. Etwas anders gesagt, könnte sich als besonders therapeutisch herausstellen, daß der Patient den Therapeuten als bedeutsamen Anderen erlebt, dessen Gefühle, Einstellungen und Werte er introjiziert; dies bewirkt eine Korrektur dessen, was der Patient mit bedeutsamen Anderen seines frühen Lebens erlebt hat.

Eine weitere Implikation könnte eine Verringerung des Unterschieds sein zwischen expressiver *Psychotherapie – einst das Kennzeichen der Psychoanalyse – und* stützender *Psychotherapie, die als typisch für andere Therapiearten betrachtet wurde. Heute erkennen wir, daß jede Form dynamischer Therapie sowohl expressive wie stützende Elemente beinhaltet.*

Wir werden bestimmt auch einen größeren Realismus und eine genauere Einschätzung der Möglichkeiten und Grenzen dessen sehen, was Psychotherapie erreichen kann. Wie sich besonders bei den verschiedenen Formen von Kurzzeittherapien oder Therapien mit Zeitbeschränkung gezeigt hat, werden die Therapeuten perfektionistische Ziele, wie sie einst die Szene beherrschten, aufgeben; sie werden erkennen, daß eine Psychotherapie nur in den seltensten Fällen dauerhafte Heilung bewirkt; sie werden toleranter werden der Tatsache gegenüber, daß viele Patienten immer wieder Hilfe brauchen. Kurz gesagt,werden sich wohl sowohl Patienten als auch Therapeuten mit Verbesserung statt mit Heilung begnügen (wenn es letztere überhaupt je gegeben hat).

Die verschiedenen Modifikationen von Theorie und Praxis, die heute im Vordergrund stehen, werden die psychodynamische Therapie weiterhin mit neuer Vitalität und Kraft erfüllen, ganz anders als noch vor wenigen Jahrzehnten, als sie von der Verhaltenstherapie praktisch überschattet wurde.

Eine Bemerkung muß noch zum enormen Zustrom von Personen, die als Therapeuten auftreten, und zum Problem der Ausbildung beigefügt werden. Wir dürfen erwarten, daß Therapeuten mit den vielfältigsten Hintergründen kommen werden, einige mit umfassender Ausbildung und Erfahrung, andere mit massiven Defiziten in dieser Hinsicht. Ebenso werden die Ausbildungsprogramme weiterhin stark divergierende Maßstäbe widerspiegeln. Viele Personen, die sich Therapeuten nennen, werden weiterhin sowohl in persönlicher als auch in professioneller Hinsicht schlecht ausgerüstet sein für das Übernehmen professioneller Verantwortung.

Die Ausbildung wird wohl besser werden, obwohl sie möglicherweise ein Flickwerk bleibt mit großen Unterschieden zwischen den verschiedenen Ausbildungsprogrammen. Wir werden aber zweifellos technologische Fortschritte in der Ausbildung sehen, z.B. den Gebrauch von Techniken wie CD-ROM und andere Neuerungen, die sich die Fortschritte im Lehrbetrieb und verwandten Bereichen zunutze machen.

Andererseits sollte man die wachsende Rolle, welche die kontrollierte Forschung spielt, nicht übersehen. Einst eine Beschäftigung einiger weniger Unerschrokkener, werden in Zukunft Praxis und Gesellschaft den Beiträgen der Psychotherapieforscher immer mehr Wert beimessen.

Und zum Schluß: Ob es uns gefällt oder nicht – die psychotherapeutische Praxis jeder Art wird stark beeinflußt werden von den Entwicklungen im Bereich der Managed Care *mit ihrem Schwerpunkt auf Kurzzeitbehandlungen für spezifische Störungen, beschränkter Zielsetzung und Kostenbegrenzung. Die unbegrenzte dynamische Psychotherapie wird weiterhin ein Luxus bleiben, den sich nur relativ wenige Mitglieder unserer Gesellschaft leisten können. Und dennoch wird eine gemächliche Form, die das Gewicht mehr auf Persönlichkeitswachstum denn auf* klinisches Management *legt, ohne Zweifel überleben, zumindest als Ideal. Dies hoffe ich.*

To forecast the future of a sprawling enterprise like psychotherapy is a daunting task and to do so in the allotted space is even more difficult. In this article I shall restrict myself to psychodynamic psychotherapy; even so I can only point to some growing edges and touch upon a few important developments.

Psychodynamic psychotherapy may be defined as "an approach to diagnosis and treatment characterized by a way of thinking about both patient and clinician that includes unconscious conflict, deficits and distortions of intrapsychic structures, and internal object relations" (Gabbard, 1990, p. 4). Psychodynamic psychotherapy remains firmly anchored in psychoanalytic theory (the terms psychoanalytic and psychodynamic are used today almost interchangeably; psychodynamic being the more generic term) and therapeutic principles enunciated by Freud many decades ago. Basic to psychodynamic thinking is the notion of unconscious conflict. However, as psychodynamic thinking has evolved, considerable attention has been paid to various aspects of personality, which includes prominently internal structures that are no longer seen as solely the products of conflicts between basic drives (sex and aggression) but are significantly influenced by interpersonal experiences with significant figures, primarily those of one's early childhood. Deficiencies and problems in personality development affect the strengths and weaknesses of intrapsychic structures that are the dynamic psychotherapist's major concern.

Equally important in the dynamic psychotherapist's approach to therapy is the emphasis on the person of the patient (or client) and his or her subjective experience. This focus diverges critically from the original Freudian emphasis on drives and their vicissitudes. At the same time, basic constructs, such as unconscious motivation, psychic determinism, transference, countertransference, and resistance have proven remarkably durable.

Helpful as these constructs are, they take second place to the dynamic psychotherapist's primary concern with the patient's "inner world" – his or her subjective experience. This emphasis on the person and the therapist's concerted effort, through participant observation, to understand another person sets psychodynamic psychotherapy apart from other approaches that view psychopathology as the resultant of impersonal biological or psychological forces which under certain circumstances may give rise to disorders or diseases.

Theoretical and clinical developments

Psychoanalytic therapy – psychoanalysis in the "classical sense" – was once thoroughly identified with Freud's postulates based on the drive-conflict model. Since Freud's death in 1939 important developments have had significant impact on therapeutic practice. The model of *classical analysis* (five weekly sessions, treatment extending over a period of years, a relatively passive therapist, therapeutic activity largely confined to transference interpretations) has undergone a significant decline, partly for reasons of inordinate expense, time commitment, limited patient suitability, and questionable benefits. The original treatment model has been replaced by various modifications, under the heading of *psychoanalytically oriented psychotherapy* and similar labels, with or without specific time-limits (see below).

Important influences on psychodynamic theory have been the theoretical and clinical contributions of (1) ego psychology, which, in the thirties, emphasized the ego's role in defenses and adaptation, represented by the work of Anna Freud in England, and in the United States by Hartmann (1939) and collaborators; (2) the writings of Erikson, Mahler, Jacobson and others who stressed developmental issues and provided the field with empirical underpinnings deriving from direct observations of infants and children; (3) the British object relations school, originating with Melanie Klein and represented by such prominent workers as Balint, Winnicott, Fairbairn, and Guntrip, as well as more recently, in the United States, by the highly influential writings of Kernberg and his followers; (4) the far-reaching teachings of self-psychology as represented by the late Heinz Kohut and his students; (5) the interpersonal emphasis anchored prominently in the teachings of Harry Stack Sullivan and his collaborators; (6) systems theory, which reflects the growing impact of family therapy and its variants; and, finally the contributions of a host of authors who, on various grounds and from different

vantage points, have taken issue with and modified the original Freudian model.

The influence of these developments on dynamic thinking and practice can be seen in the following trends:

1. Increasing attention is being paid to *disturbances and arrests in infancy and early childhood*, signifying an important departure from Freud's emphasis on the oedipal period. In particular, therapists are concerning themselves increasingly with the pathogenic consequences of deficiencies and other defects in the mother-child relationship that antedate and often greatly overshadow later conflicts. The Oedipus complex, once regarded as the watershed of all psychic difficulties, is no longer considered a universal phenomenon. Indeed, when it constitutes a problem it is now seen as the aftermath of earlier traumas the child has been unable to overcome. This new realization, far from simplifying the therapist's task, has tended to complicate the process, lengthening the treatment, and augmenting its difficulty.

2. Concomitantly, the *treatment emphasis has shifted* from the "classical" neurotic conditions (e.g., anxiety hysteria, phobias, and obsessive compulsive disorders), which Freud viewed as the primary focus of psychoanalysis, to the problems of *more difficult patients* (e.g., chronic personality disorders, including borderline conditions and narcissistic personality disorders). While many of these patients can and do benefit from dynamic psychotherapy, the task is often prolonged and exceedingly slow. Furthermore, various modifications (previously called parameters) in the management of these patients had to be introduced.

3. Partly as a function of greater integration between classical psychoanalytic and interpersonal theory and technique, new emphasis is being placed on the *dyadic character of the therapeutic relationships*. A major outcome of this development has been a radical redefinition of the cornerstones of psychodynamic therapy – transference, and its complement, countertransference. Rather than viewing transference as a distortion of psychosocial reality, the latter is now being recognized as multiple and complex (Gill, 1982, p. viii). Both patient and therapist continually contribute significantly and reciprocally to the therapeutic process which always contains real and transference elements. By the same token, countertransference is no longer regarded as an unfortunate by-product that can be eliminated or at least mitigated by the therapist's personal analysis. The therapist continually resonates emotionally to the patient and, at appropriate times, "stops the action" in order to communicate (metacommunicate) to the patient the therapist's understanding of the unfolding transference patterns. These enactments of troublesome patterns of feeling, thinking, and action typically have a long history and they are indeed the central problem or the illness being treated. Therefore, the therapist's major tool is sustained emphasis inquiry that results in "*the unfolding illumination, and transformation of the patient's subjective world*" (Stolorow, 1990, p. 126; italics in original). Analysis of the transference, thus redefined, remains the crux of what makes psychodynamic psychotherapy truly psychoanalytic, thereby reconfirming, albeit from a changed theoretical perspective, one of Freud's most profound insights.

Further implications should be noted: Because transference is shaped by the contributions of both patient and therapist, the notion of an "uncontaminated transference" is an illusion (Gill, 1982, p. 175). Second, the original notion that true transference interpretations contain no "suggestions" is untenable (Gill, 1982; Stolorow, 1990). Third, the original Freudian view of the therapist as a mirror or blank screen is incompatible with the dyadic conception of the therapeutic relationship. Even more to the point, the impersonal therapist, far from being an ideal, represents a serious and frequently noxious miscarriage of the therapeutic role. This insight is perhaps best illustrated by Kohut's (1979) two analyses of "Mr. Z." which were instrumental in his far-reaching redefinition of the therapist as an empathic listener and participant in the treatment process.

4. Thus, one of the most significant developments within psychodynamic therapy that will be predictably a central component of many forms of future psychotherapy, has been the growing recognition of and emphasis on the critical importance of the patient-therapist relationship. Freud was clearly aware that for interpretations to be effective there must be rapport between patient and therapist (Freud, 1913/1958, p. 139) and that there was a real relationship in addition to the transference relationship. However, in order to extol the uniquely technical aspects of treatment he tended to deemphasize the former and pay primary attention to the latter. Freud also recognized that it was essential to make the patient a collaborator in the treatment process, a phenomenon which has gained recent prominence in theoretical as well as in clinical writings under the broadened heading of the *therapeutic alliance*. Gabbard (1990) quotes Lipton (1977) who was impressed by the real, cordial relationship that Freud maintained with his patients (p. 85). This relationship provided a highly significant context for therapy and has been in sharp contrast to the classical model of the impersonal, austere, and detached analyst.

It took many years to legitimize the desirability – indeed the necessity – of a collaborative relationship between patient and therapist (Greenson, 1965). For such a working relationship to come to fruition, it became essential for the therapist to abandon the previously vaunted analytic incognito and to emerge more clearly as a "real" person who manifested and communicated commitment, caring, interest, respect, and human concern for the patient. Such a stance is now seen as a crucial component of the therapeutic influence.

A more "human" therapist does not necessarily prevent the emergence of negative transference either. On the contrary, a patient who can respond positively to the foregoing therapist qualities will be in a superior position to deal more effectively with negative feelings that inevitably emerge in therapy.

Also important in this redefinition of the therapeutic climate has been the work of numerous psychotherapy researchers who have called forceful attention to and identified empirically the influence of common or nonspecific factors (Butler and Strupp, 1986) as central to therapeutic change in most forms of psychotherapy. Researchers have also provided evidence that the formation of a good therapeutic alliance early in therapy may be an important contribution factor to a positive outcome. However, if a workable therapeutic alliance cannot be developed early in therapy, as may be the case with "difficult" (e.g., negativistic or hostile) patients, the prognosis for a good outcome may be seriously in doubt (Hartley and Strupp, 1983; Marziali et al., 1981).

5. Advances in *neuroscience*, and *pharmacotherapy* have been of great and trenchant importance, particularly in the treatment of depression and associated disorders. The growing biological trend in psychiatry has threatened to all but eclipse training for psychiatrists in psychodynamic therapy. Yet, while drug therapy often shows impressive results, it cannot deal with interpersonal conflicts and other aspects of patients' maladaptive behaviors that have traditionally been the concern of psychodynamic psychotherapists. There is now general recognition that psychotherapy and pharmacotherapy can be often fruitfully combined, which calls for increased collaboration among specialists.

6. Although individual psychotherapy has remained the mainstay of psychodynamic psychotherapy, *group therapy* as well as *family and marital therapy* have achieved popularity and widespread acceptance. Some of these approaches embody psychodynamic principles whereas others trace their theories and practices to other antecedents. At any rate, these treatment modalities have unique advantages as well as limitations in comparison to individual therapy. In addition to being more economical, group therapy provides patients with opportunities to learn how they function in groups, and the fantasies and problems they experience in a group setting may be conducive to therapeutic experiences not otherwise available. Marital and family therapy similarly allow the therapist to deal with couples and families as "systems."

7. Along with, and in contrast to the growing interest in the treatment of "sicker" patients – who seem to have outnumbered and replaced the classical neurotic conditions – there has been a renewed emphasis on the *briefer forms* of psychotherapy, a development that owes much of its impetus to societal pressures for accountability, cost-effectiveness, the steadily increasing demand for mental health services, and the desire of the various mental health professions to meet these needs. As a result, there has been vigorous activity in developing time-limited treatment regimens, with prominent forms being subjected to controlled research.

Early workers in the time-limited area found that contrary to then-prevalent assumptions, psychoanalytic/psychodynamic principles could be successfully applied in briefer forms (ranging from 2 to 3 sessions in crisis intervention to 25 or more in other forms), that a sizable proportion of patients could be helped in this way, and that the short-term therapist required specialized training. Koss and Butcher's (1986) review of the literature noted that most brief treatments, regardless of theoretical assumptions, share a number of characteristics: (a) promptness of intervention; (b) rapid, early assessment; (c) a quickly established interpersonal relationship from which to obtain therapeutic leverage; (d) management of temporal limitations by the therapist; (e) limitation of therapeutic goals; (f) directive management of the sessions by the therapist; (g) centering the therapeutic content around a dynamic focus or theme; (h) ventilation or catharsis, as an important part of most approaches; and (i) flexibility in choice of technique (p. 662).

There are clear indications that time-limited forms of psychotherapy, including those based on psychodynamic principles, will receive increasing attention in the future. Far from simplifying the therapeutic task, shorter forms of psychotherapy make greater demands on the therapist. Thus far, few training programs include such specialized training, which should become mandatory if for no other reason than that psychotherapy, regardless of whether time-limits are stipulated, turns out to be short-term (often on more than six sessions). Of at least equal importance in determining a good outcome are a set of patient characteristics, such as good previous adjustment, ability to form a productive therapeutic relationship from the beginning of therapy, high initial motivation to work collaboratively with a professional helper, and the absence of severe characterological problems (e.g., extreme dependency, acting out, excessive self-centeredness, and self-destructiveness).

8. As part of the foregoing trend, there has been increased pressure on the mental health professions to develop *specific treatments for specific disorders*, which have been catalogued in the now generally accepted Diagnostic and Statistical Manual (DSM-IV) of the American Psychiatric Association. The DSM, however, has been a procrustean bed for dynamic therapists, to whom the goal of developing specific treatments for specific disorders has never been congenial since their major concepts cut across the diagnostic nomenclature. Nonetheless, as a function of developments in the area of *managed care*, therapists of all persuasions are being forced to adopt this thinking. Furthermore, the widely accepted investigative model of *clinical trials*, analogous to the testing of a drug, has further supported this development.

9. The past decade has witnessed the appearance of so-called *treatment manuals*. Originally intended as research tools to lend greater specificity to a treatment modality that was to be compared with others, treatment manuals have begun to play a role in the training of therapists. Analogous to a cookbook or a flight plan, a treatment manual contains more or less specific recommendations concerning appropriate techniques and it is typically based on a set of theoretical assumptions that are thought to guide the techniques. Treatment

manuals had their origin in behavioral concepts and techniques that can be specified more easily than psychodynamic ones. However, in recent years several psychodynamic and interpersonal manuals have been developed and successfully applied (e.g., Luborsky, 1984; Strupp and Binder, 1984). Manuals also permit assessments of the extent to which a therapist adheres to a set of techniques, and various measures have been developed for this purpose. Although manuals have moved the field in the direction of greater specificity, the practice of psychotherapy requires the therapist to individualize interventions, which means that considerable individual differences remain between therapists. These differences may represent significant *qualitative* but as yet unmeasured variations in the patient-therapist interaction, which may override the contributions of technique.

Accumulating research evidence has also called attention to the fact that adherence to a set of techniques is no guarantee that a therapist practices these techniques skillfully. It is now being appreciated that adherence and skill are by no means identical, with skill being much more difficult to assess than adherence. The measurement of competence and skill has remained a critical but elusive problem that still awaits intensive study (Strupp, Butler & Rosser, 1988). In other words, the practice of psychotherapy, like the practice of medicine, remains an art, only certain aspects of which are susceptible to specification and measurement. In particular, the therapist's personality is a critical component of the therapeutic equation. Nonetheless, in keeping with contemporary trends that stress technique rather than personality variables, it is predictable that treatment manuals will increase in popularity.

10. Perhaps the most basic question faced by theoreticians, clinicians, and researchers relates to the *mechanisms of change* in psychotherapy; that is, *how personality and behavior change is achieved.* Major alternatives are (1) the patient's relationship to the therapist and (2) some form of technical interventions. In the former case, common or nonspecific factors in all good human relationships are accorded precedence whereas in the latter, specific or technique factors play a major role. In practice, change is no doubt attributable to a combination of the two sets and it may be extremely difficult, if not impossible, to disentangle their respective influence. However, since the common factors view implicitly questions the importance of technical expertise (highlight the healing aspects of the therapeutic relationship as such), the issue is likely to remain alive for some time. Stated somewhat differently, what may be most therapeutic is the patient's experience of the therapist as a significant other whose feelings, attitudes, and values are *introjected*, thus effecting *corrections* of the patient's experience with significant others in his or her early life. Another implication is the diminishing distinction between *expressive* psychotherapy, once considered the hallmark of psychoanalysis, and *supportive* psychotherapy, thought to be characteristic of other forms. It is now recognized that all forms of analytic therapy embody both expressive and supportive elements (Wallerstein, 1986).

Outlook

The various modifications of theory and practice that are in the forefront today have infused psychodynamic psychotherapy with renewed vitality and vigor, which stand in contrast to its virtual eclipse by behavior therapy only a few decades ago. Its major rival today are the various forms of cognitive therapy, with other forms running a distant third.

In practice, few therapists today call themselves "purists;" instead, eclecticism (the selected best of all approaches) seems to dominant the scene. This movement reflects a decisive departure from orthodoxy, together with much greater openness by most therapists to adapt to changing circumstances and to tailor techniques to the changing needs of patients as well as to the demands of our multifaceted society. Eclecticism, however, magnifies the task of the researcher who must look for *definable* theories and practices.

There also appears to be greater realism and a keener appreciation of the potential as well as the limitations of what psychotherapy can accomplish. As shown particularly by the various short-term or time-limited approaches, therapists have abandoned perfectionistic goals that once dominated the scene; they have realized that psychotherapy rarely heals permanently; and they have become more tolerant of the fact that many patients are in need of recurrent help. In short, they are more willing to settle for amelioration instead of cure (if the latter ever existed).

A word should be said about the enormous influx of individuals entering the arena as therapists and the problem of training. More than ever, individuals practicing today come from a wide diversity of backgrounds, some having extensive training and a broad spectrum of clinical experience while others are grossly deficient in these qualifications. By the same token, training programs reflect widely divergent standards. Although the major professional organizations have formulated criteria and instituted quality controls, many individuals who call themselves therapists are ill-equipped, both personally and technically, to assume professional responsibilities.[1] Licensing laws and a growing emphasis on ethical principles are salutary developments; however, training itself has made only slow progress. In psychodynamically oriented programs, reliance continues to be placed on (1) course work, (2) supervision, and (3) personal therapy. However, training and supervision have remained fairly unsystematic, constituting for the most part a patchwork quilt, with wide variations from

[1] Whereas psychiatry is now according psychotherapy a low priority in training, clinical psychology has embraced dynamic psychotherapy (including psychoanalysis) as never before. In the United States, the victory won by psychologists in their lawsuit against the American Psychoanalytic Association has provided greater access to training in psychoanalytic institutes whose training standards have generally been rigorous.

program to program. At the same time, competence and skill have remained difficult to define although research has begun to make some inroads into these problems. More intensive effort is greatly needed. Notable advances have come and will be coming from cognitive psychology and instructional psychology, both of which have given rise to improved learning technologies. Training in psychotherapy, by contrast, has remained largely static. Psychodynamic therapy, which clearly calls for significant interpersonal and technical skills, has made slow progress in improving its training programs although there is reason to believe that the future will witness advances at an accelerating pace.

On another front, one should not overlook the increasing role played by controlled research (cf. Bergin and Garfield, 1994). Once the esoteric pursuit of a few intrepid souls, the field and society have begun to value the contributions of the psychotherapy researcher. A cadre of sophisticated investigators have made significant strides in examining not only the global effectiveness and efficacy of various approaches but they have also directed the searchlight of research on major variables and micro events in the therapeutic process, thereby slowly influencing therapeutic practice.

In sum, psychodynamic theory and practice have proven remarkably viable and adaptable. It seems safe to predict that no single treatment model or modality will emerge in the foreseeable future; instead, psychodynamic principles, perhaps with further refinements, will undoubtedly retain their place in individual, group, family, and marital therapy. Although it remains true that nothing may be as practical as a good theory, therapists have found that it is quite feasible to work with theoretical assumptions that are relatively close to the clinical phenomena and processes that therapists must deal with on a day-to-day basis. In other words, the time of the "grand theories" (e.g., Freudian meta-psychology) is past and greater attention must now be devoted to a fuller understanding and management of basic clinical processes, such as transference, countertransference, and resistance.

Finally, whether one likes it or not, psychotherapeutic practice of all kinds will be significantly influenced by developments in the area of *managed care*, with its emphasis on short-term treatments for specific disorders, limited goals, and cost-containment. This trend is less concerned with the goal of achieving a better understanding of change processes than with issues of practical utility. Open-ended dynamic psychotherapy (including psychoanalysis) will clearly remain a luxury that relatively few members of our society can afford. However, an unhurried approach that stresses personality growth rather than *clinical management* will undoubtedly survive, at least as an ideal. That is my hope.

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[2] Because of space limitations this list of references is sharply curtailed.

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